



## **Texas Department of Insurance**

### **Division of Workers' Compensation**

Medical Fee Dispute Resolution, MS-48

7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645

518-804-4000 telephone • 512-804-4811 fax • [www.tdi.texas.gov](http://www.tdi.texas.gov)

## **MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION**

### **GENERAL INFORMATION**

#### **Requestor Name and Address**

HOUSTON ORTHROPAEDIC SURGICAL  
PO BOX 4359 MSC500  
HOUSTON TX 77210

#### **Respondent Name**

FACILITY INSURANCE CORPORATION

#### **Carrier's Austin Representative Box**

Box Number 19

#### **MFDR Tracking Number**

M4-12-0202-01

#### **MFDR Date Received**

September 21, 2011

### **REQUESTOR'S POSITION SUMMARY**

**Requestor's Position Summary:** "Ins authorized MRI and only paid on lab charges."

**Amount in Dispute:** \$1,067.20

### **RESPONDENT'S POSITION SUMMARY**

**Respondent's Position Summary:** "the attached documents reflect that the carrier preauthorized CPT Code 72149 (lumbar spine MRI with contrast). Thus, the carrier preauthorized one service (72149), and the requestor billed for a different service (72158). No preauthorization was given for the service the requestor has billed for, and thus, no reimbursement is due."

**Response Submitted by:** Flahive, Ogden & Latson, Post Office Drawer 201320, Austin, Texas 78720

### **SUMMARY OF FINDINGS**

Date(s) of Service	Disputed Services	Amount In Dispute	Amount Due
January 3, 2011	Facility Diagnostic Services	\$1,067.20	\$1,053.73

### **FINDINGS AND DECISION**

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

#### **Background**

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.600 sets forth rules for prospective and concurrent review of health care.
3. 28 Texas Administrative Code §134.403, titled *Hospital Facility Fee Guideline – Outpatient*, sets out the reimbursement guidelines for facility services provided in an outpatient acute care hospital.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:
  - 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.

- 198 – Precertification/authorization exceeded. \$0.00
- 595-001 – THE REIMBURSEMENT AMOUNT IS BASED ON THE MEDICARE REIMBURSEMENT PLUS THE PERCENTAGE INCREASE SPECIFIED BY THE STATE.
- 851-001 – PAYMENT DENIED/REDUCED FOR EXCEEDED PRECERTIFICATION/AUTHORIZATION. UMD RECOMMENDS \$0.00
- 901 – RECONSIDERATION NO ADDITIONAL PAYMENT. ORIGINAL PAYMENT DECISION IS BEING MAINTAINED. UPON REVIEW, IT WAS DETERMINED THAT THIS CLAIM WAS PROCESSED PROPERLY.
- W1 – Workers Compensation State Fee Schedule Adjustment

## **Issues**

1. Did the respondent support the insurance carrier's reasons for reduction or denial of services?
2. Are the disputed services subject to a contractual agreement between the parties to this dispute?
3. What is the applicable rule for determining reimbursement for the disputed services?
4. What is the recommended payment amount for the services in dispute?
5. Is the requestor entitled to reimbursement?

## **Findings**

1. The insurance carrier denied reimbursement for disputed services with reason codes 198 – “Precertification/ authorization exceeded. \$0.00” and 851-001 – “PAYMENT DENIED/REDUCED FOR EXCEEDED PRECERTIFICATION/ AUTHORIZATION. UMD RECOMMENDS \$0.00.” The services in dispute are facility services for the technical component of a magnetic resonance imaging procedure provided to the injured worker. The respondent argues that “the carrier preauthorized one service (72149), and the requestor billed for a different service (72158). No preauthorization was given for the service the requestor has billed for, and thus, no reimbursement is due.” Per 28 Texas Administrative Code §134.600(c), effective May 2, 2006, 31 *Texas Register* 3566, the carrier is liable for all reasonable and necessary medical costs relating to the health care listed in subsection (p) only in the case of an emergency, or when preauthorization was approved prior to providing the healthcare, or when ordered by the Commissioner. Review of §134.600(p) finds that magnetic resonance imaging services are not listed as requiring preauthorization. Although §134.600(p)(8) requires preauthorization for repeat individual diagnostic studies, the insurance carrier did not deny the services as a repeat procedure, nor was any documentation presented that a prior individual diagnostic study had been performed. The respondent has not presented any documentation to support that preauthorization was required. The Division therefore concludes that the insurance carrier's denial reason is not supported. The disputed services will be reviewed per applicable Division rules and fee guidelines.
2. Review of the submitted documentation finds no information to support that the disputed services are subject to a contractual agreement between the parties to this dispute.
3. This dispute relates to facility services performed in an outpatient hospital setting with reimbursement subject to the provisions of 28 Texas Administrative Code §134.403, which requires that the reimbursement calculation used for establishing the maximum allowable reimbursement (MAR) shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Outpatient Prospective Payment System (OPPS) reimbursement formula and factors as published annually in the Federal Register with the application of minimal modifications as set forth in the rule. Per §134.403(f)(1), the sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 200 percent, unless a facility or surgical implant provider requests separate reimbursement of implantables. Review of the submitted documentation finds that separate reimbursement for implantables was not requested.
4. Under the Medicare Outpatient Prospective Payment System (OPPS), each billed service is assigned an Ambulatory Payment Classification (APC) based on the procedure code used, the supporting documentation and the other services that appear on the bill. A payment rate is established for each APC. Depending on the services provided, hospitals may be paid for more than one APC per encounter. Payment for ancillary and supportive items and services, including services that are billed without procedure codes, is packaged into payment for the primary service. A full list of APCs is published annually in the OPPS final rules which are publicly available through the Centers for Medicare and Medicaid Services (CMS) website. Reimbursement for the disputed services is calculated as follows:
  - Procedure code 82565 has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Facility

payment for the technical component of this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(e)(1). The fee listed for this code in the Medicare Clinical Fee Schedule is \$7.22. 125% of this amount is \$9.03. The recommended payment is \$9.03.

- Procedure code 84520 has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Facility payment for the technical component of this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(e)(1). The fee listed for this code in the Medicare Clinical Fee Schedule is \$5.56. 125% of this amount is \$6.95. The recommended payment is \$6.95.
- Procedure code 72158 has a status indicator of Q3, which denotes conditionally packaged codes that may be paid through a composite APC; however, as no other composite services were billed, this service is paid separately and is not assigned to a composite APC. This service is classified under APC 0337, which, per OPPS Addendum A, has a payment rate of \$533.60. This amount multiplied by 60% yields an unadjusted labor-related amount of \$320.16. This amount multiplied by the annual wage index for this facility of 0.9902 yields an adjusted labor-related amount of \$317.02. The non-labor related portion is 40% of the APC rate or \$213.44. The sum of the labor and non-labor related amounts is \$530.46. The cost of this service does not exceed the annual fixed-dollar threshold of \$2,025. The outlier payment amount is \$0. The total APC payment for this service, including any applicable outlier payment, is \$530.46. This amount multiplied by 200% yields a MAR of \$1,060.92.

5. The total allowable reimbursement for the services in dispute is \$1,076.90. This amount less the amount previously paid by the insurance carrier of \$23.17 leaves an amount due to the requestor of \$1,053.73. This amount is recommended.

### **Conclusion**

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is \$1,053.73.

### ***ORDER***

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby **ORDERS** the respondent to remit to the requestor the amount of \$1,053.73, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

### **Authorized Signature**

_____	<u>Grayson Richardson</u>	<u>October 10, 2012</u>
Signature	Medical Fee Dispute Resolution Officer	Date

### ***YOUR RIGHT TO APPEAL***

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision* together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a *certificate of service* demonstrating that the request has been sent to the other party.**

**Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.**